STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676218	A. Building B. Wing	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jefferson Nursing and Rehabilitation Center	3840 Pointe Parkway Beaumont, TX 77706

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a safe, sanitary, comfortable and homelike environment for 1 of 18 residents (Resident #47) and 9 of the 22 tables in the dining room reviewed for environment. 1. The facility failed to ensure that Resident #47's dining table was stable and in good repair. 2. The facility failed to ensure the tables in the dining room were in good repair and not wobbly when touched. These failures placed residents at risk of injury, an uncomfortable environment, and a decrease in quality of life and self-worth.Findings included: 1. Record review of a face sheet dated 07/31/25 indicated Resident #47 was a [AGE] year-old female initially admitted on [DATE] and readmitted on [DATE]. Her diagnoses included atherosclerotic heart disease (condition where the blood vessels become narrowed and hardened due to buildup of fats in the blood vessel wall), schizoaffective disorder (mental health condition with a combination of symptoms of schizophrenia and mood disorder), major depressive disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), unsteadiness on feet, muscle wasting and atrophy (the decrease in size and wasting of muscle tissue) of lower legs, muscle weakness, and age-related osteoporosis (condition in which bones become weak and brittle). Record review of the most recent quarterly MDS assessment dated [DATE] indicated Resident #47 was usually able to understand others and usually able to make needs known. She required supervision or touch assistance for sit to stand and chair transfers. Her BIMS indicated she was moderately impaired cognitively with a score of 8. Record review of Resident #47's care plan revised on 01/24/2023 indicated she was a risk for falls and interventions included need for safe environment. During an observation and interview on 07/29/25 at 10:05 a.m., observed Resident #47 sitting at a dining table drinking coffee. Resident #47 attempted to stand up by holding onto table and pushing upward, due to wobbly/unstable table, empty coffee cup slid across table approximately 3 inches. During an interview with Resident #47, she said the table is wobbly and every time she tries to get up after meals her cup and tray slides. She said that the wobbly table makes it hard for her to stand up safely. 2. During an observation on 07/29/25 at 8:45 a.m., surveyor observed 9 of the 22 dining tables were unstable/wobbly when touched for stability. During an observation and interview on 07/29/25 at 9:00 a.m., observed the Maintenance Supervisor test the dining tables and noted 9 of the 22 dining room tables were wobbly. During an interview the Maintenance Supervisor said he was aware of previous complaints made by residents about the wobbly tables in the dining room and a work order was submitted and completed several months ago. He said he was not aware and had not received a new work order for a new concern with the dining room tables being wobbly. He said that he did not routinely check the dining tables for stability, that he made repairs as he received work order requests and priority. He said the wobbly dining room tables needed to be repaired and demonstrated what needed to be done to fix one of the dining room tables. He said having wobbly tables could place residents at risk for falls, and their food falling off the table onto them or on the ground. Record review of an electronic maintenance work order request dated 04/24/2025 authored by AD indicated area of concerns dining room/dining room tables wobble and on 05/07/2025 Maintenance Director updated the order as completed and commented that dining tables were adjusted. No indication that dining room tables are checked routinely for stability. During an interview 07/29/25 at 10:23 a.m., the DON said everyone was responsible for reporting unsafe furniture/wobbly dining tables. He said when a repair needed to be done, that he or other staff should go into the electronic maintenance work order system and report the repair needed and priority, the system would notify the maintenance department of the needed repair. He said he would then expect the Maintenance Supervisor to then address the issue and complete the repair. He said the wobbly dining room tables could place the residents at risk for falling or injuries. He said due to the grooved tile flooring in the dining room area it does cause the tables to be unsteady if placed near grooves. During an interview on 07/29/25 at 11:23 a.m., the Administrator said all staff that identify equipment or furniture in need of repair should place a repair request in the electronic maintenance work order system. She said once it is entered into the maintenance work order system, she then expected the maintenance supervisor to address the issue. She said the wobbly dining room tables could place the residents at risk for falling or injuries. Requested a policy for safe environment and the Administrator said, we follow a TELS system (building management platform designed to report work order request and request direct supply) for environmental safety and for preventative and routine maintenance which follows regulatory life safety

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents received an accurate assessment, reflective of the resident's status for 1 of 18 residents (Resident # 71) reviewed for accuracy of assessments. The facility did not accurately complete the MDS assessment to indicate Resident #71 received the anticoagulant (blood thinner) medication rivaroxaban. This failure could place the residents at risk of not receiving the appropriate care and services to maintain their highest level of well-being. Findings include:Record review of a face sheet dated 07/28/25 indicated Resident #71 was an [AGE] year-old female admitted on [DATE]. Her diagnoses included cerebral infarct (condition where brain tissue dies due to a lack of blood supply usually by blockage in a blood vessel).Record review of the most recent quarterly MDS assessment dated [DATE] indicated Resident #71 had a BIMS score of 4 indicating severely impaired of cognition and had a diagnosis of cerebral infarct. The assessment did not indicate Resident #71 had received the anticoagulant medication rivaroxaban during the last 7 days.Record review of Resident #71's care plans with a target date of 10/04/25 did not include a care plan for anticoagulant medication. Record review of the physician's orders dated 07/30/25 [VT1] indicated Resident #71 was prescribed rivaroxaban 10 mg daily for cerebral infarct with a start date of 05/17/25.Record review of Resident #71's July 2025 MAR printed 07/30/25 indicated she received rivaroxaban 10 mg daily for cerebral infarct daily with a start date of 05/17/25.During an observation and interview on 07/28/25 at 09:45 a.m., Resident #71 was lying on her bed with no bruising or bleeding observed. She was confused and unable to answer questions.During an interview on 07/30/25 at 8:22 a.m., LVN B said she was providing care for Resident #71 today. She said resident #71 was receiving the anticoagulant medication rivaroxaban. LVN B said the MDS nurses were responsible for care plans and MDSs.During an interview on 07/30/25 at 10:00 a.m., MDS Nurse C said MDS nurse K and herself were responsible for the MDSs and care plans in the facility with the Regional Case Manager as a backup for MDS and completed random audits of MDSs. MDS Nurse C said she was responsible for Resident #71's MDS and the anticoagulant medication was overlooked and not added to the MDS, or care planned. She said the Resident risk of not marking Resident #71's anticoagulant on the MDS was staff may not be made aware of what to monitor the resident for which included adverse reactions and blood clots.During an interview on 07/30/25 at 11:30 a.m., the DON said MDS Nurse C and K were responsible for all MDSs in the facility, he signed off on all MDSs and was ultimately responsible. He said Resident #71's anticoagulant should have been marked on the MDS but was overlooked. The DON said MDS Nurse C and K were educated on completion of MDSs. He said the resident risk of the MDS not marked for the anticoagulant was potentially staff not aware of needed care. He said his expectation was all MDSs be completed accurately and timely. The DON said the facility did not have an MDS policy they followed the RAI.[VT2] During an interview on 7/30/25 at 12:00 p.m., the Administrator said MDS Nurse C and K were responsible for all MDSs in the facility with the Regional Case Manager a backup that spot checked some MDS. She said Resident #71's anticoagulant should have been documented on the MDS but was overlooked. The Administrator said there was no resident risk of the MDS not marked for the received anticoagulant just an inaccurate MDS. She said her expectation was all MDS completed as accurately as possible.During an interview on 7/30/25 at 3:45 p.m., the Regional Case Manager said MDS Nurse C and K were responsible for all MDSs in the facility. She said she was the backup that checked of a random sample of resident's MDS quarterly. She said Resident #71's anticoagulant medication was overlooked during marking of the MDS. The Regional Case Manager said the MDS nurses were educated on completion of MDS, received scheduled training and online courses. She said there was no direct resident risk of an anticoagulant not marked on the MDS, not a billing factor just not accurate information to match the resident's care.Record review of Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual dated October 2023 indicated, .N0415: High-Risk Drug Classes: Use and Indication .1. Is taking check if the resident is taking any medications by pharmacological classification, not how it is used, during the last 7 days or since admission/entry or reentry if less than 7 days. E. Anticoagulant .N0415E1. Anticoagulant (e.g., warfarin, heparin, or low-molecular weight heparin): Check if an anticoagulant medication was taken by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days).

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to develop and implement a comprehensive person-centered care plan to meet each resident's medical, nursing, mental, and psychosocial needs for 1 of 18 residents (Resident #71) reviewed for care plans. The facility did not have a care plan to address Resident #71's use of the anticoagulant (blood thinner) medication rivaroxaban.This failure could place residents at risk of not having their individual needs met and not receiving needed services. Findings included:Record review of a face sheet dated 07/28/25 indicated Resident #71 was an [AGE] year-old female admitted on [DATE]. Her diagnoses included cerebral infarct (condition where brain tissue dies due to a lack of blood supply usually by blockage in a blood vessel).Record review of the most recent quarterly MDS assessment dated [DATE] indicated Resident #71 had a BIMS score of 4 indicating severely impaired of cognition and had a diagnosis of cerebral infarct. The assessment did not indicate Resident #71 had received the anticoagulant medication rivaroxaban during the last 7 days.Record review of Resident #71's care plans with a target date of 10/04/25 did not include a care plan for anticoagulant medication. Record review of the physician's orders dated 07/30/25 indicated Resident #71 was prescribed rivaroxaban 10 mg daily for cerebral infarct with a start date of 05/17/25.Record review of Resident #71's July 2025 MAR printed 07/30/25 indicated she received rivaroxaban 10 mg daily for cerebral infarct daily with a start date of 05/17/25.During an observation and interview on 07/28/25 at 09:45 a.m., Resident #71 was lying on her bed with no bruising or bleeding observed. She was confused and unable to answer questions.During an interview on 07/30/25 at 8:22 a.m., LVN B said she was providing care for Resident #71 today. She said resident #71 was receiving the anticoagulant medication rivaroxaban. LVN B said the MDS nurses were responsible for care plans and MDSs.During an interview MDS Nurse C said MDS Nurse K and herself were responsible for the care plans in the facility with ADONs responsible for acute care plans. She said the DON double checked some care plans. MDS Nurse C said she was responsible for Resident 71's MDS and care plan. She said the anticoagulant was overlooked and not added to the care plan. MDS Nurse C said the resident risk of an anticoagulant not care planned was staff may not be aware of what to monitor for the resident including for adverse reactions and blood clots.During an interview on 7/30/25 at 11:35 a.m., The DON said Resident 71's anticoagulant should have been care planned. He said it was overlooked. The DON said MDS Nurse C was responsible for care planning the long-term care residents including Resident #71 and MDS Nurse K was responsible for care planning skilled residents (resident's stay paid for by Medicare and Managed care). He said the staff were educated on care planning. He said the resident risk of an anticoagulant not care planned was staff could be unaware of care. The DON said his expectation was care plans to be accurate.During an interview on 07/30/25 at 12:10 p.m., the Administrator said the DON, ADONs and MDS Nurses were responsible for care plans in the facility and the IDT team reviewed the care plans in morning meeting daily. She said Resident #71's anticoagulant was overlooked. The Administrator said there was no resident risk of an anticoagulant not care planned. She said staff may not know all the information, but it would not affect patient care because the staff was providing the care for Resident #71.During an interview on 07/30/25 at 12:20 p.m., ADON A said she was responsible for Resident #71 care plan update, and she overlooked the anticoagulant. She said the MDS nurses were responsible for care plans and she was the backup. ADON A said she was educated on care plans and should have care planned Resident #71's anticoagulant. She said the resident risk of an anticoagulant not care planned was CNAs may not be aware to monitor the resident for bruising or bleeding due to the care plan adds information to the CNAs Kardex (summary of resident care needed). ADON A said the nurses were aware and were monitoring Resident #71 for side effects of the anticoagulant medication. Record review of a facility policy titled, Care Plan Revisions Upon Status Change dated 10/24/22, indicated, .The purpose of this procedure is to provide a consistent process for reviewing and revising the care plan for those residents experiencing a status change . 1. The comprehensive care plan will be reviewed, and revised as necessary, when a resident experiences a status change. f. Care plans will be modified as needed by the MDS Coordinator or other designated staff member.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on observation, interview, and record review the facility failed to store, prepare, distribute, and serve food under sanitary conditions in 1 of 1 preparation kitchen. * The facility did not ensure steam table pans did not have brown colored buildup on the outside edges* The facility did not ensure baking sheets and baking pans did not have brown colored buildup on the outside edges* The facility did not ensure the dish machine was sanitizing the dishes* [NAME] L did not wash hands when entering the kitchen * [NAME] L did not have the beard guard completely covering facial hair These failures could place all residents who eat from the kitchen at risk for foodborne illnesses. Findings included:During an observation on 07/28/2025 at 08:40 a.m. during the initial tour of the kitchen indicated there were the following:-one (1) 1/2 size baking sheet with dark brown colored build up on the outside edges;-ten (10) full size baking sheets with dark brown colored buildup on the outside edges and stacked together;-two (2) full size shallow baking pans with brown colored buildup on the outside edges and stacked together;-eight (8) full size steam table pans with brown colored buildup on the outside edges and stacked together; and-three (3) 1/2 size deep steam table pans with brown colored buildup on the outside edges and stacked together. During an observation and interview on 07/28/25 at 09:20 a.m. the dish machine was checked for sanitation level with the SFDM and the strip had no color change. DA H checked the sanitation solution container, and it was almost empty and not pumping the solution into the dish machine. DA H said she checked the level prior to starting the dishwashing process but she did not check the sanitation solution container to ensure there was enough solution in the container. During an interview on 07/28/25 at 09:25 a.m. the SFDM said the container should be checked when the levels are checked to ensure there was enough solution to wash the dishes. She said if the sanitation solution was not getting into the dish machine, then the dishes were not being sanitized. She said the outcome could be food borne illnesses from the dishes not being sanitized properly. During an interview on 07/28/25 at 11:20 a.m. the RDD said the pans and baking sheets should not have the buildup on them because it could cause a fire or spread foodborne illnesses. She said the dishwasher should always check the level of the sanitation solution container when they check the dish machine to ensure there was enough solution. She said items washed but not sanitized could spread foodborne illnesses. Record review of a Mechanical Cleaning and Sanitizing of Utensils and Portable Equipment Policy dated 10/01/18 indicated: Policy: The facility will follow the cleaning and sanitizing requirements of the state and US Food Codes for mechanical cleaning in order to ensure that all utensils and equipment are thoroughly cleaned and sanitized to minimize the risk of food hazards.Procedure:.2. Make sure that the automatic detergent dispenser and/or liquid sanitizer injector is working properly.7. If a machine that uses chemicals for sanitizing is in use, follow these guidelines: .c. Chemical added for sanitization purposes must be automatically dispensed. d. Utensils and equipment must be exposed to the final chemical sanitizing rinse in accordance with the manufacturer's specifications for time and concentration.f. A test kit or other device that accurately measures the parts per million concentration of the solution must be available and used. During an observation and interview on 07/30/25 at 11:42 a.m., observed [NAME] L outside the back kitchen exit door vaping (inhaling a mist of nicotine and flavoring from a handheld device) and he reentered the kitchen, picked up a kitchen utensil, and began frying fish. He did not wash his hands or apply a beard hair restraint upon reentering the kitchen. [NAME] L said he forgot to wash his hands and apply a new beard restraint upon reentering the kitchen after his break but knew he should have. [NAME] L said the potential risks of not washing hands and nor wearing a beard hair restraint would be passing germs or hair falling into food. During an interview on 07/30/25 at 01:01 p.m. the RDD said staff was supposed to wash their hands after coming from outside and apply a new beard hair restraint every time they reenter the kitchen from outside. She said not following those steps could potentially lead to the spread of germs. Record review of an undated Personal Hygiene and Handwashing policy provided on 07/31/25 by the RDD indicated the following: Learning objectives: Upon completion of the in-service, the participant will: 1. Identify importance of personal hygiene. 2. Demonstrate appropriate hand washing procedure. 3. Identify how personal hygiene and hand washing impact food safety and prevention of foodborne illness. Outline for discussion 1. Why is good hygiene important?a. A person can host dangerous pathogens that when transferred to food can cause foodborne illness.b. Good hygiene and proper handwashing helps protect the people eating the food you make from becoming sick. 2. When to wash hands? a. When entering food prep area.c. Before handling clean equipment and serving utensils. d. Before handling or serving food.g. After returning to a food prep area from any other area (includes rest room).h.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 4 halls.The facility failed to ensure CNA J performed proper hand hygiene while entering and exiting residents' room on hall 300 while providing ice and water for hydration services. The facility failed to ensure CNA D did not touch hydration cart ice scoop to the inside of resident's cup while providing ice and water for hydration services. The facility failed to ensure CNA J and CNA G performed proper hand hygiene and disposal of soiled (dirty) cup while providing ice and water for hydration services. This failure could place residents at risk for the spread of infection. Findings include: During observation of hydration services (ice and water) from hydration cart (2 level-cart, 45 liter ice chest with cubed ice, ice scoop, single packaged straws, bag of Styrofoam cups and package of lids for cups) on 07/28/25 from 2:00 p.m. to 2:20 p.m., CNA J did not wash or sanitize his hands prior to entering/exiting rooms or handling ice scoop, new cups, lids, old used cups and residents personal used insulated cups for the following rooms on Hall 300: entered room [ROOM NUMBER] walked to both resident bedside table touched them with ungloved hands while picking up both residents' used Styrofoam cups and discarded them into the trash can. CNA J walked to the rolling ice cart, and got two Styrofoam cups out of the bag, picked up the ice scoop with ungloved hands, opened ice chest lid then and scooped ice into both cups and went into resident's bathroom filled up resident's cups with faucet water, placed lid onto cups and inserted straws. CNA J touched both bedside tables when putting the cups down, exited resident room and did not wash or sanitize his hands. He then entered room [ROOM NUMBER] repeated the same process but dropped 2 cup lids in resident bathroom on the floor, he picked lids up off the floor discarded them into the trash, returned to the hydration cart and got 2 new lids and placed them on resident's cup and did not wash or sanitize his hands. CNA J stood in the doorway of room [ROOM NUMBER] (room door with Enhanced Barrier Precaution signage) took his bare left hand and scratched his head. CNA J did not wash or sanitize his hands after scratching his head. He then entered room [ROOM NUMBER]A, touched resident's bedside table while grabbing the used cup and threw it in the garbage. He exited the room and did not wash or sanitize hands. CNA J moved hydration cart to an activity room after providing hydration services, he did not remove the ice from the ice chest or sanitize the cart. During an interview on 07/28/25 at 3:00 p.m. with CNA J, he said he was responsible for providing Hall 300 hydration services and was supposed to preform hand hygiene before and after entering residents' rooms. He said, I forgot to hand sanitize between resident hydration services, and I should have used hand sanitizer or washed my hands when I picked the two lids up off the floor with my hands. He said that the hydration cart was sanitized, and new ice added to ice chest at the beginning of each shift. He said the risks associated with not performing hand hygiene was potentially passing germs to residents. He said he has been checked off on handwashing and has received training on hand washing when he was hired and annually. During an interview 07/28/25 at 3:59 p.m. with LVN E, said she was the charge nurse for hall 300 and supervised the CNAs working her hall. She said her expectations for CNA's was to take care of the residents, use gloves while caring for residents and wash hands when they enter a resident's room during care and after care. She said she has educated her aides on preforming hand hygiene before entering a resident's room and after leaving from a resident's room. She said the risk of staff not preforming hand hygiene was the potentially spread of germs and infection. LVN E said she was trained and had a skill check- off on hand hygiene. During an observation and interview on 07/29/25 at 12:01 p.m. CNA D was observed providing hydration services to residents on hall 300, while refilling resident's personal cup with ice, CNA D touched ice scoop to the inside of resident's cup. During an interview with CNA D, she said she shouldn't have touched the ice scoop to the resident's personal cup because it could potentially spread germs and infections. She said she has been trained and had completed a skills check- off on preforming proper hand hygiene. During an observation on 07/29/25 at 2:29 p.m., CNA J and CNA G was observed providing hydration services on Hall 300, CNA J dropped a Styrofoam cup, CNA G picked up the cup and put it on the second shelf on the hydration cart. CNA J entered room [ROOM NUMBER], picked up used cup went back to the hydration cart and scooped ice from ice chest into the resident's cup. CNA G verbally told CNA J don't you need to get a new cup instead of bringing their old one to the cart and touching the scoop to the cup? Isn't that cross contamination? CNA J then replied No, it's a new cup from this